SUBJECT: **First Aid**	NUMBER: 1-36.01
EFFECTIVE DATE:	REVIEW DATE:
NMMLEPSC STANDARDS: OPR.16.01, OPR.17.01	APPROVED: 2/22/18 Sheriff

I. POLICY

Sworn employees of the Valencia County Sheriff's Office are required, under their official duties, to give first aid to the injured. The agency will ensure members are trained in programs to best address the individual first aid training needs of our employees and community.

II. TACTICAL TRAUMA KIT

Law enforcement officers, other emergency services personnel and bystander civilians injured by penetrating objects may suffer from uncontrolled hemorrhage. With the goal of maximizing survival, trauma kits will be issued address optimal care that could be utilized in these types of situations.

A. Definitions

1. Tourniquet: Defined as any limb constrictive device, whether improvised or commercially manufactured, used in an attempt to stop extremity bleeding.

2. Pressure Dressings - Pressure dressings are adequate to stop most cases of hemorrhage, whether it occurs from the extremities or other parts of the body. Commercially available bandages or other compression dressings improvised with large amounts of gauze and an elastic bandage that is wrapped around the wounded limb may beused.

B. Nearly all external bleeding can be controlled by direct pressure with a dressing. The affected limb may also need to be elevated. Use of direct pressure over the supplying artery is an additional option when bleeding persists. However, in certain situations, the direct use of a tourniquet should be considered. Responding agency personnel must consider both the tactical situation and injury severity when deciding which hemorrhage control technique to employ.

C. Procedures

1. The wounded person is initially assessed and determined to have severe extremity bleeding controllable with the equipment or resources immediately at hand.

Indications for tourniquet use included all of the following:

a. Penetrating trauma from gun shots, stabbings, or other body penetrating objects.
b. Deputies working in tactical environments who may benefit from a self-applied tourniquet for "care under fire."
c. Incidents with penetrating and/or blast injury to limbs.
d. Industrial accidents where limbs are trapped or shredded by industrial machinery.
e. Failure to stop bleeding with direct pressure dressing(s)
f. Injury does not allow control of bleeding with pressure dressing(s)
g. Extreme life-threatening limb hemorrhage, or limb amputation/mangled limb with multiple bleeding points, to allow immediate management of airway and breathing problems.
h. Point of significant hemorrhage from a limb is not accessible due to entrapment (unable to provide direct pressure.)
i. Major incident or multiple casualties with extremity hemorrhage and lack of resources to maintain simple methods of hemorrhage control.

2. Removal:

It is advisable that the tourniquet be left in place once initially applied and not loosened. EMS or other advanced medically trained personnel (medical doctor, registered nurse) will determine the need for removal.

3. Transport and Handover

All tourniquet usage must be prominently documented and communicated on transfer of care to minimize the likelihood that a tourniquet will be overlooked by subsequent care providers. Time of application must be recorded either on a triage tag, the tourniquet itself (if designated space is available) or physically written on the skin of the victim.

4. Any amputated limb should ideally be transported with the wounded person to hospital even if it appears unsalvageable as tissue may be utilized for skin cover and reconstruction of the severed limb.

5. Equipment to carry

Every sworn officer assigned to uniformed patrol duties shall be trained in bleeding control basics and will carry the trauma kit on their person.

6. Training

All sworn officers will receive approved training in bleeding control basic course as required by NMLEA. Training must include hemorrhage control techniques, including use of tourniquets, and pressure dressings.

III. NASAL NALOXONE (NARCAN)

In 2001 the New Mexico State Legislature provided authority and release from liability for persons "other than a licensed health care professional" to administer an opioid antagonist to an individual whom they believe to be experiencing a drug overdose (New Mexico State Law, NM Stat § 24-23-1). Law enforcement officers can serve as "trained targeted first responders" as outlined in New Mexico Department of Health rules describing opioid antagonist programs (NMAC 7.32.7.1).

A. Definitions

1. Naloxone is a fast acting opioid antagonist used in emergency medicine to rapidly reverse opioid related sedation and respiratory depression.

2. Naloxone has been successful in treating overdoses of Heroin and other opioids such as Morphine, Fentanyl, Oxycodone, Oxycotin, Percocet, Percodan, Hydrocodone, and Vicodine.

3. Naloxone is also called "Narcan", "Nalone", and "Narcant".

B. Training

1. Prior to issuance of the naloxone kit, deputies shall receive a minimum of four hours training in opioid overdose recognition and response, including the administration of intra-nasal naloxone, by a trainer approved by the New Mexico Department of Health.

2. Deputies shall receive a minimum of a one hour refresher training every year, which may be done in conjunction with First Aid/Cardiopulmonary Resuscitation (CPR).

3. The Sheriff shall designate a member of agency to serve as the coordinator responsible for administration of the agency's intranasal naloxone program.

C. Issuance

1. Naloxone will be provided in a clearly marked kit for intranasal administration. Each intranasal naloxone kit shall include:
   a) Two (2) single dose naloxone hydrochloride containing 4mg in 0.1ml of nasal spray and within their manufacturer assigned expiration dates.
   b) Instructions on overdose response and naloxone administration

2. All deputies who are trained and issued naloxone are required to maintain the intranasal Naloxone kit in their assigned vehicle or on their person at all times while on duty. Naloxone is temperature sensitive and must be stored at a temperature between 59° F to 77° F. Naloxone will not be left in vehicles while off duty.

D. Overdose Response and Use of Naloxone

1. Ensure scene safety for yourself and other first responders.

2. When using the intra-nasal naloxone kit deputies shall adhere to universal precautions and follow the overdose response procedure as directed by this policy and the Department of Health Law Enforcement Naloxone Training:

   a) Determine non-responsiveness, absence or difficulty breathing
   b) Update dispatch on potential overdose (dispatch will activate emergency medical services)
   c) Administer first dose of intranasal naloxone
   d) If after 3-5 minutes of administering first dose of naloxone, there is no improvement (victim remains unconscious, no independent breathing) administer second dose of naloxone.
   e) If the individual remains non-responsive following administration of second dose of naloxone, consider initiating CPR.
   f) All subjects who are given naloxone will require assessment by emergency medical services (EMS) regardless of mental status.

3. The intranasal naloxone device shall be properly disposed of by emergency medical personnel at the scene.

E. Reporting: After utilization of naloxone, personnel will:

1. Prepare a "Naloxone Usage Report" and complete an incident report to include a description of the individual's condition, behavior, deployment of naloxone, deployment results, details of call, and any other details the reporting deputy feels are relative to the incident.

2. The above reports shall be reviewed and approved according to standard operating procedures and a copy will be submitted for review by the program coordinator.

F. Storage and Replacement

1. Inspection of the intranasal naloxone kit shall be the responsibility of the issued deputy and shall be conducted each month by checking the expiration date found on either box or nose spray

3. Missing, damaged or expired naloxone kit(s) will be reported directly to the on-duty supervisor. The on-duty supervisor will then report issue to the program coordinator.

4. Requests for replacement naloxone kit(s) will be submitted to the program coordinator.

5. Supervisors shall conduct inspection of the naloxone kits on a monthly basis and denote the equipment's condition in the vehicle inspection report.

6. If one (1) dose in a kit is administered during the normal course of duty a replacement kit will be requested. A complete kit will be considered a kit with two (2) full doses including two (2) nasal spray devices and instructions on overdose response and naloxone administration.